



SAN FRANCISCO UNION SQUARE
166 GEARY STREET, SUITE 1502
415.445.9513

EAST BAY PINOLE
1700 SAN PABLO AVENUE, SUITE F
510.724.6662

www.yourfaceinourhands.com

Patient Registration

Today's Date: _____

Last Name First Name Middle

Address

City State Zip

Date of Birth Age Driver's License

Social Security Number: _____

Primary: _____ Alternate: _____
 home cell other home cell other

OK to contact you at the listed numbers and/or leave a message? YES NO

Email: _____

OK to email you confidential information? YES NO

OK to email you our periodic newsletter? YES NO

Emergency Contact Relationship to patient

Primary: _____ Alternate: _____
 home cell other home cell other

Whom may we thank for your referral?

Website _____

Google Real Self YouTube Yelp

Personal referral: _____ Physician Other: _____

Medical History

Name

First Last Middle

Please list any current and ongoing medical conditions:

Medical

- | | |
|--|---|
| <input type="checkbox"/> Vision Deficits | <input type="checkbox"/> Are you currently pregnant? |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Are you currently breastfeeding? |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Are you attempting pregnancy? |
| <input type="checkbox"/> Other: _____ | |

Surgical

Previous Operations:

Medications

Name	Dosage (if known)	Name	Dosage (if known)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take, or have you taken:

- Steroids in the past year Antidepressants? _____ Date: _____

Allergies

- NONE If YES, please list: _____

Personal Physician

Name of regular physician: _____ Specialty: _____
Business Telephone: () _____ - _____ Date of last physical exam: _____

Personal History

Do you smoke?: NO YES _____ Pack(s) per day

Family History

Is there a history of the following in your immediate family? If so, please list the family member beside the disease.

	YES	NO	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Family Member: _____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Family Member: _____
Anesthesia Reaction	<input type="checkbox"/>	<input type="checkbox"/>	Family Member: _____

Patient Questionnaire

Name: _____ Age: _____ Date: _____

Hometown: _____ Current City of Residence: _____ Profession: _____

Have you had previous treatments? None Botox Fillers Laser

Have you had any previous surgeries? _____

Is there an upcoming special date you are working with? No Yes

*** There may be bruising after injections. Please allow between 7-10 days**

What would you like to Discuss with Dr. Mabrie today?

COMMENTS:

Specific facial areas you want to improve? _____

GOALS TODAY:

- Treat Single Area
- Look Younger
- Look Less Tired
- Look Better/ More Attractive
- Other: _____

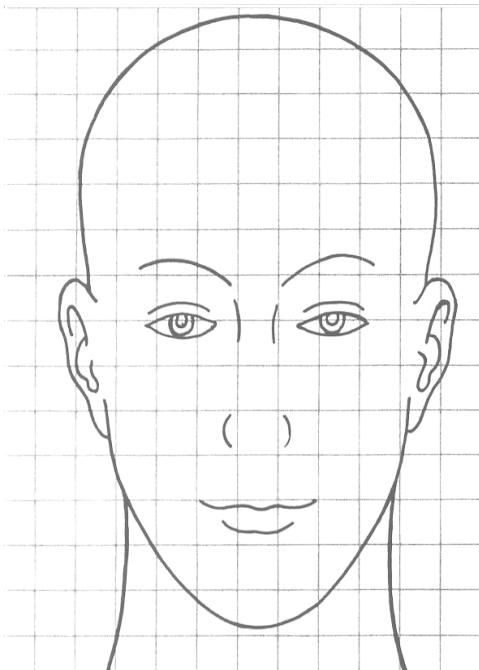
CONCERNS:

- Bruising
- Pain
- Looking "Overly Done"
- Other: _____

EXAM:

Fitzpatrick: I II III IV V VII

DOCTOR'S NOTES:



RHYTIDS:	MILD	MOD.	SEV.
<input type="checkbox"/> Forehead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Glabella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crow's Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> N/L Fold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SHADOWS:			
<input type="checkbox"/> Tear Trough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lat. Orbit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cheeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Oral Comm.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
UNDERDEVELOPED:			
<input type="checkbox"/> Cheeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nasal Bridge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nasal Tip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Asymmetry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Informed Consent – Botox | Dysport | Injectable Filler

Patient's name: _____

You are electing to receive an injection of neurotoxin (Botox, Dysport, etc.), and/or dermal filler (Restylane, Perlane, Juvederem, Radiesse, Artefill) by Dr. David C. Mabrie. While neurotoxins and dermal fillers are non-surgical, it is important for you to know and understand the risks involved with these treatments.

Botox / Dysport

Botox/Dysport decreases expression lines by temporarily paralyzing small facial muscles. An adjacent muscle may be weakened for several weeks after an injection. _____.

Injectable Dermal-Fillers

Depending on the filler and the area treated, the cosmetic benefits normally last between 6 to 12 months. Complications may include: poor cosmetic result, severe bruising, infection, swelling, allergic reactions, numbness, pigment change, injury to skin, nerves or arteries. _____.

Facial fillers have been studied and approved by the FDA for the nasolabial folds. Other areas are Off-Label use. _____.

Dermal-Fillers to the Nose (Non-Surgical Rhinoplasty)

Injections to the nose performed after a Rhinoplasty may compromise the blood supply to the skin and result in skin loss. Injections to the tip after Rhinoplasty have an increased risk of vascular compromise and tissue loss. _____.

Additional Information

It is important that you **plan for possible bruising, swelling, discoloration, and/or tenderness to the treatment areas**. These post-injection side-effects usually last 10 to 14 days, but may take longer to resolve. Following your treatment, it is crucial that you remain patient as your body heals. Dr. Mabrie will address any and all residual concerns during your follow-up appointment.

Your 2-week follow-up appointment is an essential component designed to monitor progress and provide opportunity for additional treatment, as both you and Dr. Mabrie deem necessary, in order to achieve your desired aesthetic goals.

Bruising may range from a small discoloration (mild), to black/blue/purplish in color (severe). Injections under the eye can cause a **black eye**. Redness and swelling at the injection site usually resolves within a few hours. Medication and vitamins such as: Aspirin, Ibuprofen, Coumadin, St. John's Worth, Vitamin E, or Fish Oil may increase the possibility of bruising. _____.

Although most patients are pleased to experience immediate results, multiple treatments may be necessary to achieve ideal results due to an individual's anatomical or physiological structure. **Again, your follow-up appointments are an imperative factor for achieving optimal results.** _____.

I hereby state that I have read (or it has been read to me), and understand this consent and the information contained in it. I have had the opportunity to ask questions about the treatment including risks, benefits and alternative methods of treatment. All my questions about the procedure or procedures have been answered in a satisfactory manner, and I have been thoroughly informed prior to treatment and prior to my signature.

Patient Signature

Date

Witness Signature

Date

I have provided and explained the information set forth herein and answered all questions of the patient, or the patient's representative, concerning treatment.

Doctor's Signature

Date



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Botox | Dysport | Injectable Filler Financial Responsibility Agreement

Neurotoxins and/or dermal fillers are elective, non-surgical treatments with temporary results. Opting for a treatment is not a guarantee of results. Dr. Mabrie cannot provide any guarantees against complications, bruising, swelling, and/or risks.

Further, Dr. Mabrie cannot provide you any guarantees of your level of satisfaction, correction, and/or happiness with this treatment. Please make sure to understand the risks, potential complications, limitations, and consequences of neurotoxins and/or dermal fillers before proceeding with a treatment or signing this Financial Responsibility Agreement and accompanying Informed Consent. _____

Your payment is due at the time of treatment and includes Dr. Mabrie's expertise, professional services, and the treatment product. You understand that your payment is **non-refundable**. _____

The fees charged for this procedure do not include any potential, future costs for additional procedures that you elect to have or require in order to revise, optimize, or complete your outcome. Additional costs of medical treatment(s) is your responsibility should complications develop from neurotoxin or dermal filler treatments. In signing the Financial Responsibility Agreement and the Informed Consent for this procedure, you acknowledge that you have been informed about their risks and consequences and accept responsibility for the clinical decisions that were made along with the financial costs of all future treatments.

I understand and acknowledge that there are no refunds for treatment(s) and results are not guaranteed. _____

I hereby state that I have read (or it has been read to me), and understand this consent and the information contained in it. I have had the opportunity to ask questions about the treatment including risks, benefits and alternative methods of treatment. All my questions about the procedure or procedures have been answered in a satisfactory manner, and I have been thoroughly informed prior to treatment and prior to my signature.

Patient Signature

Date

Witness Signature

Date

I have provided and explained the information set forth herein and answered all questions of the patient, or the patient's representative, concerning treatment.

Doctor's Signature

Date